

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0538
TTY: (800) 526-5812

Dear DME Providers:

The enclosed enrollment documents for the Illinois Medical Assistance Program have been designed for use by all providers with specific sections relating to different provider types. Please read the enclosed instructions prior to completing the forms.

Your enrollment request will be processed, upon completion and receipt of the enclosed: Medical Provider Enrollment Application Form (HFS 2243), Provider Agreement Form (HFS 1413) and Enrollment Disclosure Statement Form (HFS 1513).

Before your enrollment is approved, your qualifications to become a Medicaid provider will be investigated by the Office of Inspector General. This may include an on-site physical inspection of your office, equipment, record keeping and other areas.

Each provider is required to report the Name and Federal Employee Identification Number of the entity to whom payments are to be made on their behalf. Enclosed for your convenience is a Request for Taxpayer Identification Number and Certification Form (W-9) to be completed and returned with your enrollment request.

Please Note: The Provider Agreement requests names, social security number and percentage of ownership of owners/stock holders who own 5% or more of the stock/shares. If Not Applicable (NA), please write “**none**” to indicate.

No enrollment will be effective until the Provider Participation Unit approves the application. No service should be provided prior to notification of enrollment approval. **Payment will not be made for services rendered prior to the effective date of enrollment.** Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider. **Participation is not transferable.**

Once enrolled, a Provider Information Sheet will be mailed to the participating provider at the payee location(s) listed on the enrollment application. The Provider Information Sheet is to be reviewed for accuracy and used as a reference in preparing claim forms. Reporting of discrepancies or changes to the information originally submitted to IDHFS are to be noted on the Provider Information Sheet and mailed to the address below. An updated Provider Information Sheet will then be mailed to the payee location(s).

A Provider Handbook of the specific rules and regulations relative to the type of service (s) you provide will be added to the Internet as revisions are completed or mailed to your office address upon request. Handbooks on the Internet can be located at <http://www.hfs.illinois.gov/handbooks/>

The Illinois Department of Healthcare and Family Services appreciates your interest in enrolling in the Illinois Medical Assistance Program. If you have any questions regarding the completion of the enclosed forms, Please call the Provider Participation Unit at (217) 782-0538. Otherwise, please return the completed forms to the address below.

Illinois Department of Healthcare and Family Services
Provider Participation Unit
P.O. Box 19114
Springfield, Illinois 62794-9114

Patricia A. Law, Acting Bureau Chief
Bureau of Comprehensive Health Services